Nevada HMO Quality Indicators Report

2009 ANNUAL UPDATE

Bureau of Health Statistics, Planning, Epidemiology, and Response - Nevada State Health Division - Nevada Department of Health and Human Services

NEVADA HMO QUALITY INDICATORS REPORT
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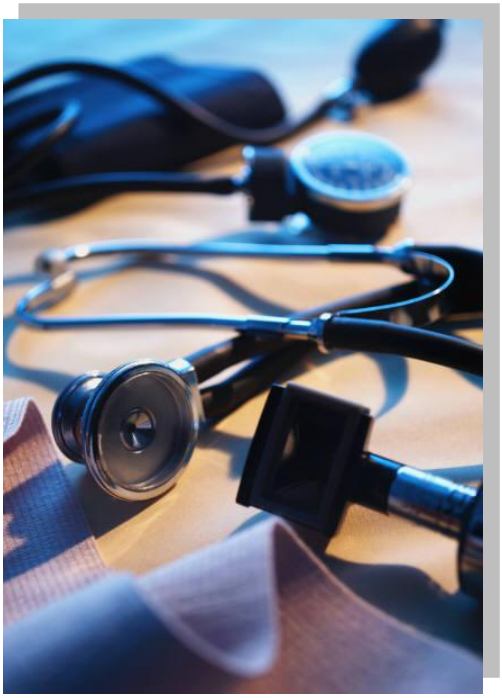

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SECTION I

EXECUTIVE SUMMARY

Nevada Administrative Code (NAC) 695C.275 requires Health Maintenance Organizations (HMOs) to report specific quality indicators, as defined by the State Board of Health annually by calendar year. The indicators, referred to as quality and performance measures, are part of the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a standardized data set of quality and performance measures widely used in the managed care industry. HEDIS® was developed and is maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting, and improving the quality of care. HEDIS® data are compiled for accredited and non-accredited health plans from publicly-reported and non-publicly reported measures, as applicable, and national, regional, and state averages are calculated. HEDIS® indicators are reported retrospectively, using calendar year data. For example, 2009 data will be reported in 2010. Historically, out of over 50 HEDIS indicators, the Board has selected the following seven indicators deemed most important to Nevada's public health:

- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status – Combo 2 and Combo 3
- Comprehensive Diabetes Care – HbA1c Testing
- Emergency Department Visits
- Adults' Access to Preventive/Ambulatory Health Services
- Children and Adolescents' Access to Primary Care Practitioners

The quality indicators, reviewed on the following pages, are for commercial populations only and are self-reported by each of the six Nevada licensed HMOs with commercial members. Currently, the six active Nevada licensed HMOs who serve commercial populations and are required to self-report HEDIS® quality and performance indicators annually to the Health Division, on behalf of the Board are:

- Aetna Health, Inc.
- Health Plan of Nevada
- HMO Nevada (Anthem)
- Hometown Health
- PacifiCare of Nevada, Inc.
- Saint Mary's HealthFirst

The HEDIS® indicators reported by Nevada HMOs for 2009 in this report were selected based on several factors, including:

- Increasing incidences of both breast and cervical cancer remain statistically significant in the state of Nevada and the CDC has reported that screenings for these types of cancer have been shown to decrease mortality by 20 percent to 30 percent or more.

- Childhood immunizations have been made a priority by the state of Nevada and the Nevada Managed Care Quality Improvement Council (NVmcQIC) members took the opportunity to successfully propose this indicator as a replacement for the Cesarean sections indicator retired by HEDIS® at the end of calendar year 2003.
- The prevalence of diabetes is rising rapidly throughout Nevada, as well as the nation, establishing the need for a comprehensive diabetes care indicator. Recommended by the American Diabetes Association, hemoglobin A1c (HbA1c) testing has become the gold standard for assessing and monitoring blood glucose control, significantly reducing complications from diabetes.
- The final three indicators allow the Board to have an overview of patterns of utilization, access, and availability for the commercial HMO commercial populations, pursuant to Nevada Revised Statutes (NRS) 695C.080(2)(b) and NAC 695C.125(b)(2).

After careful review of the 2008 calendar year data, the NSHD, in consensus with NVmcQIC, recommended that the Board select the same list of indicators to be reported retrospectively for calendar years 2010 and 2011.

Section II provides information about the commercial populations for each Nevada HMO, as of December 31, 2009. These data are self-reported to the Nevada State Health Division. A chart detailing the total Nevada HMO commercial population for the last five years of reporting is included.

There are five key factors that continue to contribute to the decline in commercial HMO enrollment over recent years:

1. State population growth without subsequent growth in HMO enrollment;
2. An aging population with an increased number of Medicare participants;
3. An increase in the uninsured population consistent with state growth;
4. An increased participation in other health insurance options (eg., Medicaid, SCHIP, PPOs, indemnity plans, medical discount plans, etc.) and self-funded plans (including the Plan for State employees); and
5. The current economic situation, both statewide and nationally.

Section III details a brief description of methods of reporting, measure rotation, eligible population, continuous enrollment, and confidence interval, as applicable.

***Special Note**:* Health plans with smaller member enrollments may not have large eligible populations for certain measures. A small denominator reduces the reliability of a rate, as it is not as precise as a larger one. Consistent with past years reports and in accordance with HEDIS® 2010 technical specifications, if the denominator is less than 100 and greater than 30, the Health Plan will be included in the Nevada average calculation, in the rate table and reflected on the graph, respectively. A Health Plan with a denominator of less than 30 will be included only in the rate table; however, it will be excluded from both the Nevada average calculation and on the graph.

Section IV provides information regarding the mission, membership, and objectives for the Nevada Managed Care Quality Improvement Council (NVmcQIC). This is followed by the formal Charter for NVmcQIC.

Section V of this report details each of the seven HEDIS® 2010 quality indicators for calendar year 2009. The first page contains a brief description of the HEDIS® 2010 indicator, its significance, the HEDIS® 2010 measurement criteria (i.e. denominator and numerator descriptions), and the applicable data collection method. This description is followed by a bar graph illustrating each HMO's rate. The graphs also include both the Nevada average and the National average, respectively for each indicator, as applicable. The Nevada average is calculated by the Health Division based on the data reported by each Health Plan. The national averages are obtained from NCQA's Quality Compass® 2010, based on audited data from approximately 404 commercial HMOs, representing over 94 million covered lives. All six Nevada HMOs submitted audited data and the audits were performed by NCQA-certified auditors. The table following each graph demonstrates Plan-specific data for each indicator, including numerators and denominators for the individual quality indicators, the rates, and confidence intervals, as applicable. A summary of the Nevada results, followed by the HMOs' barrier analysis and interventions, is also included.

Section VI includes applicable Nevada average trends for each Quality Indicator Rate reported.

There are three primary issues that will have continuous impact on future rates for all indicators:

- Annual HEDIS® Technical Specifications changes
- Preventive care recommendation modifications based on new research studies and best practices
- Compliance with more rigorous HIPAA regulations that may affect the availability of data reported

SECTION II

Commercial Populations of Nevada Licensed HMOs as of December 31, 2009

HMO	State Triennial Quality Exam	Service Areas	2009 Enrollment, % Change from 2008
Aetna Health Inc. 4040 S. Eastern Avenue Suite 240 Las Vegas, Nevada 89119	NCQA Accreditation 4/2009; next exam due 4/2012	Clark, Nye (Pahrump only), and Washoe counties	2008 = 14,798 2009 = 10,787 (-27%)
Health Plan of Nevada PO Box 15645 Las Vegas, Nevada 89114	NCQA Accreditation 4/2009; next exam due 4/2012	Carson City, Clark, Douglas, Esmeralda, Lincoln, Lyon, Mineral, Nye and Washoe counties	2008 = 288,064 2009 = 275,806 (-4%)
HMO Nevada 9133 Russell Road Las Vegas, Nevada 89148	URAC Accreditation 1/2010; next NV Triennial exam due 1/2013	Clark, Carson City, Pershing, Churchill, Lyon, Nye, Washoe, Lincoln, Esmeralda, White Pine, Elko, Douglas, Humboldt, Eureka, Storey, Lander, Mineral Counties	2008 = 6,043 2009 = 5,764 (-5%)
Hometown Health 830 Harvard Way Reno, Nevada 89502	CMS Qualification 6/2010; next exam due 6/2012	Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Pershing, Storey, Washoe, and White Pine counties	2008 = 27,008 2009 = 23,944 (-11%)
PacifiCare of Nevada, Inc. 5995 Plaza Drive, Mailstop CA112-0267 Cypress, CA 90630 Attn: West Region Regulat ory Affairs (Note: Subsidiary of UnitedHealthcare)	Note: PacifiCare of Nevada, Inc. retired its NCQA accreditation as of April 2010. Membership will transition to other UnitedHealthcare plans by 1/1/2011.	Carson City, Clark, Douglas, Esmeralda, Lyon, Mineral, Nye, and Storey counties	2008 = 24,517 2009 = 13,486 (-45%)
Saint Mary's HealthFirst 1510 Meadow Wood Lane Reno, Nevada 89502	NCQA Accreditation 6/2008; next exam due 6/2011	Washoe, Carson, Douglas, Lyon, Storey, Humboldt, Eureka, Elko, White Pine, Pershing, Churchill, Mineral, and Lander	2008 = 23,216 2009 = 19,594 (-16%)

Nevada Health Insurance Coverage

The following summary of health insurance coverage in Nevada was modified from data available through Kaiser State Health Facts (http://www.statehealthfacts.org). These data reflect the health insurance coverage status of Nevadans compared to the nation for 2008 (most recent data available). Nationally, Nevada ranks 9th (1st having the highest rates) for the percentage of the total population being uninsured with 18 percent being uninsured. Nationally, the average percentage of persons uninsured is 15.4 percent. The most common type of insurance coverage in Nevada is employer-paid, representing over 58 percent of the total population. This is a slightly higher percentage than the nation average of employer-paid insurance at 52.3 percent. It is important to note, however, that the most recent data available for these indicators is from

2008 and since that point in time Nevada's unemployment rate has skyrocketed. As of October 22, 2010, Nevada's unemployment rate has increased to 14.4 percent, which is the highest rate in the nation among states. Therefore, it is expected that a much greater percentage of Nevada's population has lost their insurance benefits due to unemployment or their employer ceasing to offer coverage. According to the 2009 Current Population Survey by the United States Census Bureau (http://www.census.gov/hhes/www/cpstables/032010/health/h10_000.htm), from 2008 to 2009, the number of uninsured person nationally increased from 15.4 percent to 16.7 percent. Also noted was that, "This is the first year that the number of people with health insurance decreased since 1987, the first year that comparable health insurance data were collected." In this report, it was noted that 8.8 percent of children under the age of 19 with household incomes at or below 200 percent of the federal poverty limit in Nevada were reported as having no form of health insurance, as compared to the national average of 6.6 percent. The percentage of Americans relying on government health insurance has increased as well from 2008 to 2009, at 29.0 percent and 30.6 percent respectively. Again, this is the highest percentage seen since the data began being collected in 1987.

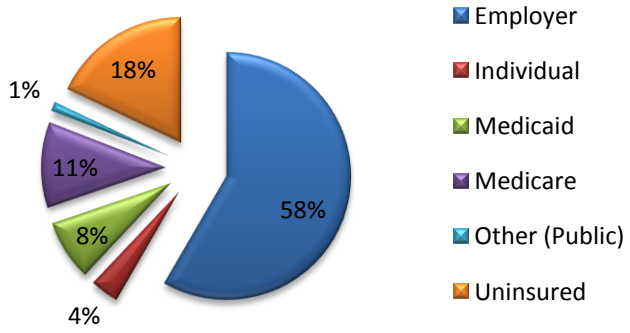
Health Insurance Status of the Total Population, July 2009*

Type of Insurance Coverage	Nevada		United States	
	Number (#)	*Percentage (%)*	*Number (#)*	*Percentage (%)*
Employer	1,500,400	58.4	157,194,100	52.3
Individual	94,700	3.7	13,995,800	4.7
Medicaid	199,600	7.8	42,326,300	14.1
Medicare	282,700	11	37,183,500	12.4
Other (Public)	29,600	1.2	3,505,000	1.2
Uninsured	464,100	18	46,339,500	15.4

**Most recent data available*

As of July 2009, Nevada ranks 24th (1st having the most) nationally for the number of HMOs operating in the state. In Nevada, the HMO penetration rate is 19 percent as compared to 21.7 percent in the United States. The total HMO enrollment as of July 2009 in Nevada was 494,183 (ranking Nevada 27th highest nationally for HMO enrollment).

Nevada Health Insurance Coverage by Type, 2008*



SECTION III

HEDIS® DATA REPORTING

HEDIS® Overview

The Healthcare Effectiveness Data and Information Set (HEDIS®) are the standardized quality and performance measures most widely used in the managed care industry. HEDIS® was developed and is maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting, and improving the quality of care. HEDIS® data consist of national, state, and regional averages of accredited and non-accredited health plans, and are compiled from publicly reported and non-publicly reported measures, as applicable.

Originally, HEDIS® was designed to meet the needs of private employers as purchasers of health care. Later, it was adapted for use by public employers, regulators, and consumers.

Reporting Periods and Methodology

HEDIS® indicators are reported retrospectively, using previous calendar year data, for claims and encounters incurred. One of two methodologies may be employed to report each indicator: administrative or hybrid. Each HMO determines which data collection method to employ, based on the HEDIS® measurement criteria and available resources.

The Administrative methodology requires the managed care organization (MCO) to identify the eligible population and numerator, using transaction data or other administrative databases. The MCO reports a rate based on all members who meet the eligible population/denominator criteria and who, through administrative data, are found to have received the service identified in the numerator.

The Hybrid method requires the MCO to identify the numerator through both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. The MCO reports a rate based on members in the sample who, through either administrative or medical record data, are found to have received the service identified in the numerator. This methodology is very labor intensive and requires more data collection time than the administrative methodology.

Optional Measure Rotation

Measure rotation, an NCQA approved strategy, allows a health plan to use the audited and *reportable* rate from the prior year's data collection, in lieu of collecting the data for the measurement year. Each year, NCQA specifies a list of HEDIS® measures eligible for rotation

for that year. Measures are rotated on a structured schedule and are eligible for rotation every other year. The heath plan may not rotate a measure in a year that the measure is not eligible for rotation. For this report, none of the applicable Nevada-reportable measures are eligible for rotation for HEDIS® 2010.

Eligible Population

The eligible population is the number of health plan members that meet all the specified denominator criteria for each measure. Denominator criteria may include age specifications, continuous enrollment, benefits, membership date range, and event requirements. Using the administrative methodology of calculating measures, the eligible population is the denominator. Using the hybrid methodology, the denominator is a systematic sample drawn from the eligible population.

Optional exclusion criteria have been developed for several measures, to ensure a higher degree of confidence and reliability in HEDIS® results. Because of the effect on the size of the denominator, it may impact a Plan's ability to improve its rate for a measure.

Continuous Enrollment

Continuous enrollment is specific for each measure and specifies the minimum amount of time a member must be enrolled in the health plan in order to be included in the measure. Using continuous enrollment criteria ensures health plans have enough time with the member to provide the recommended services.

DATA ANALYSIS

Quality and Performance Indicator Average

The Nevada HMO average rate is the average of the six HMO providers, who serve commercial populations, within the state. This report uses NCQA's calculation, which is shown in Figure 1 below:

Figure 1: Nevada HMO Average Performance Rate

$$AR_i = (\sum \frac{n_i}{d_i}) / P$$

Where AR = Average Rate for Nevada HMOs
Where *i* = HEDIS® measurement
Where *n* = numerator in HMO *i*
Where *d* = denominator in HMO *i*
Where *P* = number of HMOs

Confidence Interval

A confidence interval is a range of lower bound and upper bound values equally spread below and above the estimated performance rate. A 95 percent confidence interval infers that with 95 percent certainty the expected performance rates are within the specified lower and upper bound values. Typically, when a sample size is less than 50, a confidence interval is not calculated. The data analysis in this report considers the gap in the HMO rate and the National benchmark rate by comparing confidence intervals. If the HMO does not meet the national benchmark standards, the confidence intervals will not overlap, and there will be a *significant difference* between the two rates. If the HMO meets the national benchmark standards, the confidence intervals will overlap, and there will be *no significant difference* between the two rates.

DATA RESULTS

Results are compiled and formatted into graphs and tables, and can be found in Section V of this report. Each graph displays data for a single Quality Indicator and includes each HMO's rate, the Nevada average, and the National average, respectively. The graph is followed by a table which displays data for that Quality Indicator, including each HMO's numerator and denominator, the applicable rate, the confidence interval, the upper and lower bound values, the Nevada average, and the National average.

Trend Analysis

In order to evaluate performance growth or improvements, a trend analysis for 3 years is presented, whenever possible. Trend analyses can be found in Section VI of this report.

Barrier Analysis

A Barrier Analysis is a qualitative analysis that can be considered a gap analysis. The expectation is for each HMO Indicator Rate to meet or exceed the National average, and the gap is the difference between the HMO Indicator Rate and the National Benchmark Rate. In the event of a difference, each HMO provides expertise, insight and self-examination about information that cannot be quantified, and is necessary to understand the barriers and how they may be overcome. The HMOs provide a collaborative analysis used to assist the Plans in developing appropriate intervention strategies to impact improvement. The Barrier Analyses and Intervention Strategies are included in Section V of this report, and follow the summary for each Quality Indicator.

Assumptions

The information from these statistical analyses is best interpreted as a general guide to quality and performance. Each national quality and performance indicator rate is a benchmark. A

benchmark serves as the most feasible rate, given the barriers. The information does not allow conclusions to be drawn about the Nevada HMOs or their quality performance. Inferences may be considered, although these must be set in reference to the seven reported quality indicators.

Section III Source: *HEDIS® 2010, Volume II, Technical Specifications*

SECTION IV

NEVADA MANAGED CARE QUALITY IMPROVEMENT COUNCIL (NVmcQIC)

The Nevada State Health Division wishes to acknowledge the contributions of the Nevada Managed Care Quality Improvement Council in the compilation of this report, and thank them for their collaboration and assistance. In 2003, Nevada HMOs formed the Nevada Managed Care Quality Improvement Council to identify and promote collaborative opportunities and initiatives for improving and enhancing the quality of care and service in managed care. Prior to this, the Nevada HMOs had an informal work group that interacted with the Health Division, including collaborating on the compilation of the annual quality indicators report. The NVmcQIC Charter is as follows:

Nevada Managed Care Quality Improvement Council

Charter

Mission Statement:
To promote quality initiatives and improve health care and service provided by managed care organizations in Nevada.

Objectives:

- *Serve as advisory council to the State of Nevada on quality initiatives in managed care.*
- *Advise the State of Nevada on quality indicators to be used for statewide reporting.*
- *Identify opportunities and promote collaborative initiatives to improve the quality of care and service in managed care.*
- *Share results of quality initiatives among NVmcQIC members, State of Nevada, and the public, as appropriate, to further promote quality of care and service in managed care.*
- *Review state regulatory requirements and proposed legislation as they impact managed care quality programs and make recommendations to the State.*

Membership:

- *Each Health Plan will designate one (1) primary representative. All meeting materials and/or correspondence will be sent to this individual, who may share this information with other Plan staff as needed.*
- *NVmcQIC members represent quality improvement activities of their respective Health Plans.*
- *Representatives from the Nevada State Health Division are invited to attend the meetings and participate in an advisory capacity only.*

Meeting schedule, location, and logistics

- *Meetings are held on a quarterly basis.*
- *To facilitate participation by all Health Plans, meeting locations rotate quarterly among the Health Plans in Northern Nevada and Southern Nevada.*
- *Meeting times are from 10:00 AM to 11:30 AM*
- *Hosting Health Plan is responsible for:*
  - *Serving as facilitator for the meeting*
  - *Providing teleconference arrangements and capability*
  - *Developing the agenda and providing meeting materials to primary Health Plan representatives*
  - *Providing note summary of the meeting*
  - *Annual review and distribution of NVmcQIC Charter—January Meeting Only*
  - *Quarterly review, update and distribution of NVmcQIC Contact List*

SECTION V

Section V Sources: *HEDIS® 2010, Volume I, Narrative*; *HEDIS® 2010, Volume II, Technical Specifications*; and *Nevada HMOs serving commercial populations*

NEVADA HMOs BREAST CANCER SCREENING RATES for COMMERCIAL POPULATIONS in 2009

Breast cancer is the most common type of cancer among American women according to the Centers for Disease Control and Prevention (CDC). It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20 percent to 30 percent among women 40 and older. A mammogram is a low dose x-ray of the breast that can reveal tumors too small to be felt by hand. It can also show other changes in the breast that may suggest cancer.

Measurement Criteria

Rate: The percentage of women age 40-69 years, continuously enrolled for the measurement year and the year prior to the measurement year, who had a mammogram to screen for breast cancer.

Numerator: One (or more) mammogram(s) during the measurement year or the year prior to the measurement year

Denominator: The eligible population. *Optional exclusions*: 1) Women who had a bilateral mastectomy. 2) Women with evidence of two unilateral mastectomies.

Data collection method: All six HMOs used the administrative method.

Chart 1. 2009 Breast Cancer Screening Rates for Commercial Populations (Ages 40 to 69 years)

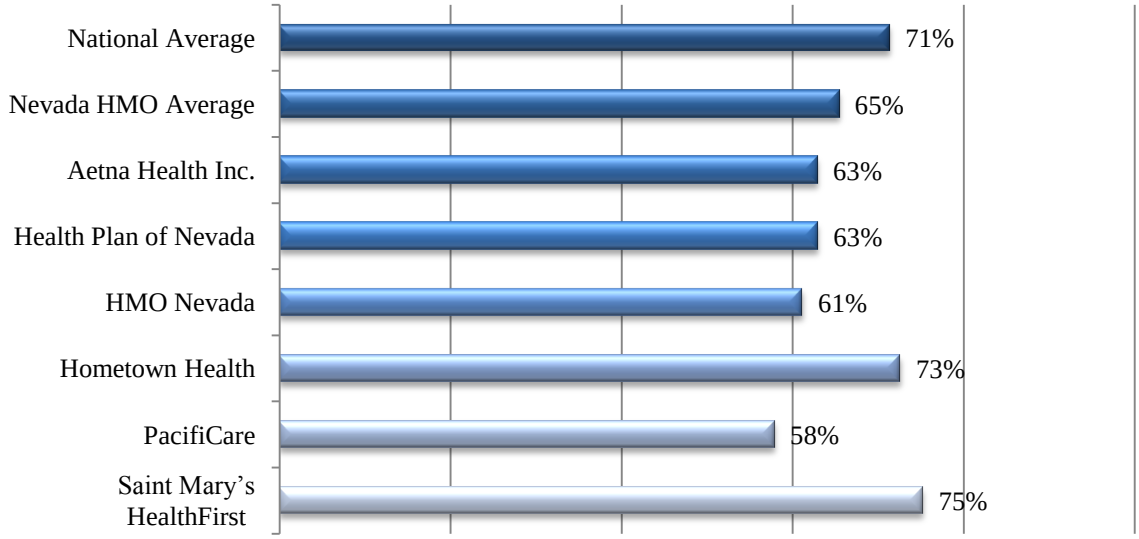


Table 1A: 2009 Breast Cancer Screening Rates for Commercial Population (Ages 40-69 years)

Nevada Licensed HMO	Patients Screened	Total Eligible Patients	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			71.31%			
Nevada HMO Average	29,280	45,758	65.42%	0.54	64.87%	65.96%
Aetna Health Inc.	567	902	62.86%	3.98	58.88%	66.84%
Health Plan of Nevada	23,609	37,537	62.90%	0.62	62.28%	63.51%
HMO Nevada	228	373	61.13%	6.34	54.78%	67.47%
Hometown Health	1,534	2,114	72.56%	2.23	70.33%	74.80%
PacifiCare	973	1,682	57.85%	3.10	54.74%	60.95%
Saint Mary's HealthFirst	2,369	3,150	75.21%	1.74	73.47%	76.95%

Summary

Historically, for many years, HEDIS® required this data be reported only for women ages 52 – 69 years. For HEDIS® 2007 (calendar year 2006), three rates were reported according to two age stratification bands and the third was the overall rate: 1) 40 – 51 years; 2) 52 – 69 year; and 3) a total rate for ages 40 – 69 years. HEDIS® 2008 was the baseline year for the two new rates. HEDIS® 2009 (calendar year 2008) eliminated the two age stratification rates and only the total is now reported.

The 2009 Nevada average for the total screening rate (40 – 69 years) is 65.42 percent, which is the same as the 2008 rate. It is over 5 percentage points below the national average of 71.31 percent. Overall, the Nevada averages for this measure have slowly declined since 2003.

For the Nevada HMOs, a chief area of ongoing concern is the lack of care coordination between Primary Care Practitioners (PCPs) and OB/GYN practitioners, as this may result in missed opportunities to refer patients for mammography screenings. The HMOs continue to evaluate continuity of care strategies between PCPs and OB/GYNs, in order to determine how to improve and enhance communications. Table 1B outlines the comprehensive efforts the HMOs are making for improving this rate.

Table 1B. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Breast Cancer Screening Rates in 2009

2008 Results	2009 Results	Barrier Analysis	Interventions To Address Barriers
Nevada Total Average 65% **National Total Average 70%**	**Nevada Total Average 65%** **National Total Average 71%**	**Member Focused Barriers**: • Member not aware of importance of breast cancer screening • Member not aware it is a Plan benefit • Member fears results • Member has no time • Member doesn't believe it is an effective diagnostic exam • Member believes the cost of co-pay is too high • Member reluctant due to discomfort of exam • Member may be deterred due to cultural issues • Fear of radiation exposure • Impact of current economic conditions on member's ability to afford co-pay, limiting access to services • Member does not establish relationship with selected PCP • Recommended guidelines have changed and may be confusing to members **Practitioner Focused Barriers**: • Lack of communication between PCP and OB/GYN, impacting completion of screening and/or test result availability • Practitioner not aware of his/her influence on member compliance • Missed opportunity to refer patient • Practitioner has ineffective tracking mechanism for identifying who needs screening • Practitioners may not be educating members to recent changes to guidelines **Other Barriers:**	**Member Focused Interventions:** • Extended hours and more locations for increased availability • Open access to OB/GYN • Waiver of co-pay • Individual member incentives • Mailings to members informing them of the importance of breast cancer screening and clarifying multiple guidelines – members encouraged to discuss best option with PCP • Article in member newsletter and on HMO web site, at least annually • Annual distribution of preventive guidelines to members • Online accessibility of preventive guidelines • Telephone outreach informing members of the importance of screening • Reminder notices sent by contract radiology facilities and/or Health Plans • Promotion in collaboration with the American Cancer Society. Developed interview-based video, now available on the ACS web site. **Practitioner Focused Interventions:** • Education of practitioners as to their importance in influencing members to receive screening mammograms • OB/GYN mailings encouraging communication of Mammogram and/or PAP to the PCP • Annual distribution of Preventive Guidelines to all practitioners • Preventive Guidelines in Practitioner Manuals and posted on HMO website • Surveys of practitioners to determine barriers • Generation of quality reports of individual OB/GYNs and PCPs • Articles in practitioner newsletters • Practitioner rosters of members needing screening along with a chart reminder tool • Recognition programs for practitioners who achieve high performance for this indicator • Educational materials provided to practitioners for distribution to members

		• Recent research conflicts with current recommendations **Plan Barriers:** • Data completeness: difficult to capture data from non-Plan practitioners • Inability to obtain data from military agencies and the VA system	

NEVADA HMOs CERVICAL CANCER SCREENING RATES for COMMERCIAL POPULATIONS in 2009

Cervical cancer is the most highly preventable form of gynecological cancer. It can be detected in its early stages by regular screening using a Pap test, which can reduce the chance of death from cervical cancer by as much as 75 percent. A number of organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 18.

Measurement Criteria

Rate: The percentage of women age, 21 – 64 years, continuously enrolled for the measurement year and the two years prior to the measurement year, who had one or more Pap tests to screen for cervical cancer.

Numerator: One (or more) Pap test(s) during the measurement year or the two years prior to the measurement year

Denominator: The eligible population. *Optional exclusion*: Women who had a hysterectomy, with no residual cervix.

Chart 2. 2009 Cervical Cancer Screening Rates for Commercial Populations (Ages 21 to 64 years)

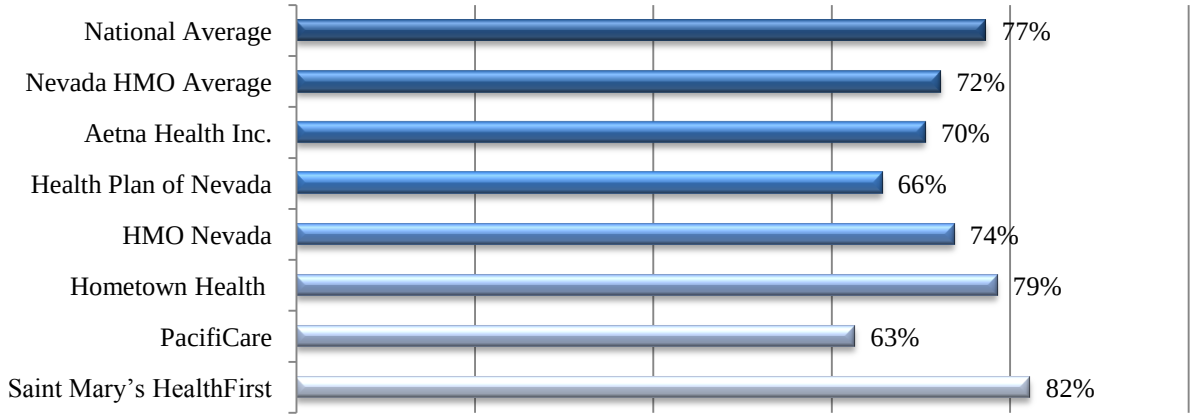


Table 2A: 2009 Cervical Cancer Screening Rates for Commercial Populations (Ages 24-64 years)

Nevada Licensed HMO	Patients Screened	Total Eligible Patients	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			77.27%			
Nevada HMO Average	37,434	55,566	72.17%	0.45	71.71%	72.62%
Aetna Health Inc.	658	934	70.45%	3.49	66.96%	73.94%
Health Plan of Nevada	30,174	45,993	65.61%	0.54	65.07%	66.14%
HMO Nevada	140	190	73.68%	7.32	66.36%	81.00%
Hometown Health	2,246	2,861	78.50%	1.70	76.80%	80.20%
PacifiCare	1,201	1,920	62.55%	2.74	59.81%	65.29%
Saint Mary's HealthFirst	3,015	3,668	82.20%	1.37	80.83%	83.56%

Summary

The 2009 overall Nevada average was 72.17 percent, which is over 5 percentage points below the National average. In 2008, the Nevada average was 75 percent, which shows an overall annual decrease on this measure of almost 3 percent. Saint Mary's HealthFirst and Hometown Health both exceeded the National average.

Table 2B outlines the comprehensive efforts the HMOs are making for improving this rate. As with breast cancer screening, one key issue may be a lack of care coordination between PCPs and OB/GYN practitioners, resulting in possible missed opportunities for screening referrals.

Table 2B. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Cervical Cancer Screening Rates in 2009

2007 Results	2008 Results	2009 Results	Barrier Analysis	Interventions To Address Barriers
Nevada Average 74% **National Average 82%**	**Nevada Average 75%** **National Average 81%**	**Nevada Average 72%** **National Average 77%**	**Member Focused Barriers**: • Member fear of test results • Member is not aware it is a Plan benefit • Member does not have money for co-payment or believes it is too high • Member is not aware of importance • Member may view only needed if sexually active • Member has no time • Member reluctance due to discomfort of exam • Member may be deterred by cultural issues • Member may be embarrassed • Member unable to have test performed due to physical impairment, including pain or illness • Impact of current economic conditions on member's ability to afford co-pay, limiting access to services • Member does not establish relationship	**Member Focused Intervention**: • Open access to OB/GYN • Individual member incentives • Annual mailings to members informing them of the importance of cervical cancer screening • Article in member newsletter and on HMO website, at least annually • Annual distribution of preventive guidelines and posting on HMO website • Telephone outreach informing members of the importance of screening **Practitioner Focused Interventions**: • Generation of quality reports of individual OB/GYNs and PCPs • Training/education sessions for PCPs by OB/GYNs to increase comfort level in performing Pap

			with selected PCP **Practitioner Focused Barriers:** • Appointment time constraints • PCP comfort level in performing exam • PCP not aware of members needing screenings • Missed opportunity to refer patient to OB/GYN • Lack of communication between PCP and OB/GYN, impacting completion of screening and/or test result availability • Practitioner not aware of his/her influence on member compliance • Practitioner has ineffective tracking mechanism for identifying who needs screening **Plan Barriers:** • Data completeness: difficult to capture data from non-Plan practitioners • Inability to obtain data from military agencies and the VA system	smears and pelvic exams • Letter from OB/GYN to PCP, or vice versa, communicating that Pap smear and/or pelvic exam have not been done • OB/GYN mailings encouraging communication of Pap and/or Mammogram results to the PCP • Distribution of Preventive Guidelines to all practitioners, including in Practitioner Manuals and on HMO website • Articles in practitioner newsletters • Practitioner rosters of members needing screening along with a chart reminder tool

NEVADA HMOs CHILDHOOD IMMUNIZATION STATUS – COMBINATIONS 2 and 3 for COMMERICAL POPULATIONS in 2009

Childhood immunizations help prevent serious illnesses, such as polio, whooping cough, mumps, measles, and chicken pox. During the past century, successful childhood vaccination has led to dramatic declines in many life-threatening diseases. The consequences of vaccine-preventable diseases are quite serious and include blindness, hearing loss, liver damage, coma, and death. While immunization coverage is high among children in the U.S., it is vital to maintain these levels to eliminate the threat of vaccine-preventable diseases. Prevention of even "mild" diseases saves millions of dollars and hundreds of lost school days for the children and lost work days for their parents/guardians.

Measurement Criteria

Rates: The percentage of children two years of age, continuously enrolled for the 12 months prior to the child's second birthday, who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three H influenza type B (HiB), three hepatitis B, one chicken pox (VZV), and four pneumococcal conjugate vaccines on or before the child's second birthday.

Numerator – Combo 2: Children who received four DTaP, three IPV, MMR, three HIB, three hepatitis B, and one VZV on or before the child's second birthday.

Numerator – Combo 3: Children who received all antigens listed in Combination 2 and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Denominator: The eligible population. *Optional exclusion*: Children who had contraindication for a specific vaccine, on or before their second birthday.

Chart 3A. 2009 Childhood Immunization Status Rates for Commercial Populations - Combo 2

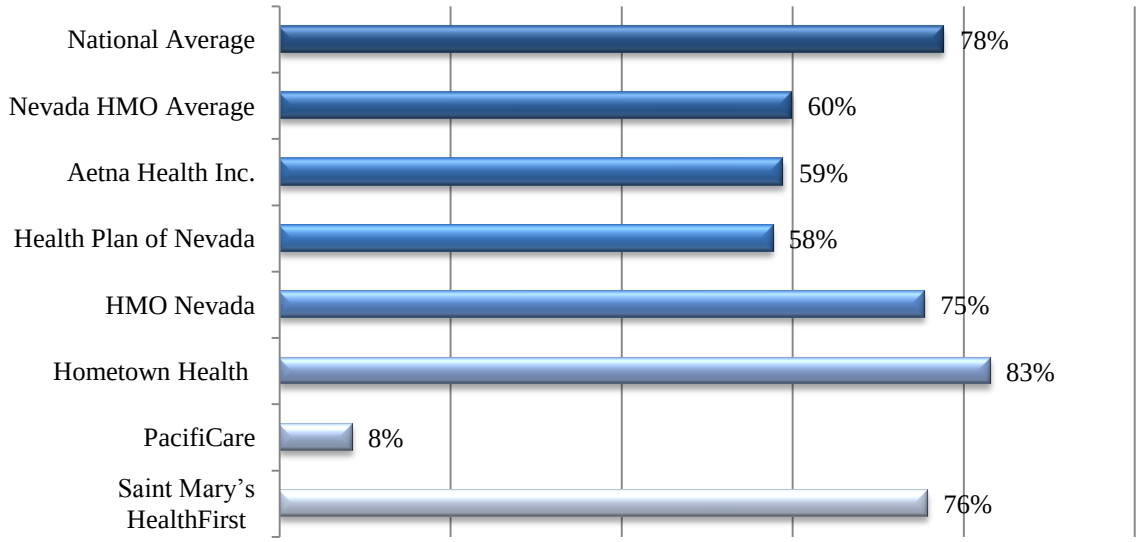


Table 3A: 2009 Childhood Immunization Status Rates for Commercial Populations - Combo 2

Nevada Licensed HMO	Patients Screened	Total Eligible Patients	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			77.70%			
Nevada HMO Average	741	1,165	59.88%	3.53	56.35%	63.41%
Aetna Health Inc.	53	90	58.89%	13.37	45.52%	72.26%
Health Plan of Nevada	237	411	57.66%	6.30	51.36%	63.97%
HMO Nevada	46	61	75.41%	12.58	62.83%	87.99%
Hometown Health	221	266	83.08%	4.95	78.13%	88.04%
PacifiCare	9	106	8.49%	19.32	-10.83%	27.81%
Saint Mary's HealthFirst	175	231	75.76%	6.37	69.39%	82.13%

Note: Immunization rates for PacifiCare of NV, Inc were reported using Administrative methodology

Chart 3B. 2009 Childhood Immunization Status Rates for Commercial Populations - Combo 3

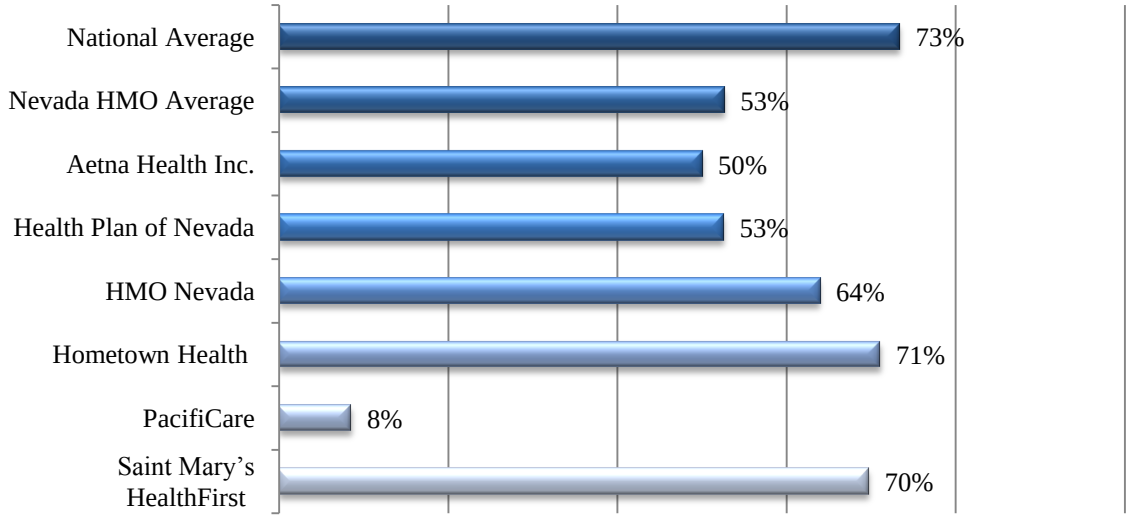


Table 3B: 2009 Childhood Immunization Status Rates for Commercial Populations - Combo 3

Nevada Licensed HMO	Patients Screened	Total Eligible Patients	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			73.37%			
Nevada HMO Average	659	1,165	52.62%	3.82	48.81%	56.44%
Aetna Health Inc.	45	90	50.00%	14.77	35.23%	64.77%
Health Plan of Nevada	216	411	52.55%	6.67	45.88%	59.23%
HMO Nevada	39	61	63.93%	15.27	48.67%	79.20%
Hometown Health	189	266	71.05%	6.48	64.57%	77.54%
PacifiCare	9	106	8.49%	19.32	-10.83%	27.81%
Saint Mary's HealthFirst	161	231	69.70%	7.12	62.58%	76.82%

Note: Immunization rates for PacifiCare of NV, Inc were reported using Administrative methodology

Summary

HEDIS® 2010 (calendar year 2009) is the sixth reporting year for Childhood Immunization Status – Combination 2 and only the third reporting year for Combination 3. For Combination 2, the 2009 Nevada average was 59.88 percent, which represents an overall decrease of 13 percent from the 2008 Nevada average of 73 percent. At 59.88 percent, Nevada was almost 18 percent below the National average. The 2009 Nevada average for Combo 3 was 52.62 percent, a decrease of over 6 percent from 2008. It is 20 percent below the National average.

Effective January 1, 2009, the State of Nevada no longer provided universal vaccine coverage. This may impact future rates, and the Plans have noted a 20 percent decrease in member immunizations during calendar 2009. It is hypothesized that PCPs who can no longer afford to purchase vaccines are most likely referring children to local/community public health clinics. As

of July 1, 2009, all immunizations provided to Nevada children must be reported to the statewide immunization information system (i.e. WebIZ). WebIZ will provide immunization data to the Plans for members who are vaccinated by non-Plan practitioners and may stabilize the perceived decrease. The registry is expected to bridge key gaps for collecting more accurate immunization data, as immunizations may be given at different sites and the PCP may not have complete and up-to-date immunization information for the child. Additionally, parents may believe that the risks of immunizing outweigh the benefits, and delay or decline immunization. Table 3C outlines the comprehensive efforts the HMOs are making to improve this rate.

Nevada immunization rates are a priority for both the Nevada State Health Division and the HMOs. The HMOs have proactively worked with the Health Division and contributed to the development of the Immunization Strategic Plan, a coordinated statewide effort to improve the immunization rates in Nevada. Also, the Health Division Immunization Registry Program Manager is an ad hoc advisory member to NVmcQIC.

Both the NVmcQIC members and Nevada State Health Division staff are actively involved with the Northern and Southern Nevada Immunization Coalitions. These coalitions are a diverse partnership of individuals, businesses, and organizations committed to improving and protecting the health of children, adolescents, adults, and seniors in Nevada. Their mission is to promote health and prevent the incidence of vaccine preventable diseases in Nevada through community partnerships and education. Each coalition addresses immunization issues at the local level through developing partnerships and organizing special projects, while supporting a statewide initiative of increasing immunization rates.

The Northern Nevada Immunization Coalition (NNIC) was established in 1995 in response to the extremely low immunization rate of Washoe County's two-year-olds. NNIC serves Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Mineral, Pershing, Storey, Washoe and White Pine counties. The Southern Nevada Immunization Coalition (SNIC) serves southern Nevada counties including Clark, Esmeralda, Lincoln and Nye. It was established in 1997, in response to the extremely low immunization rate of Clark County's two-year-olds.

Table 3C. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Childhood Immunization Status-Combos 2 and 3 in 2009

2007 Results	2008 Results	2009 Results	Barrier Analysis	Interventions to Address Barriers
Combo 2 Nevada Average 63% **National Average 81%** **Combo 3**	**Combo 2 Nevada Average 73%** **National Average 81%** **Combo 3**	**Combo 2 Nevada Average 59.9%** **National Average 77.7%** **Combo 3**	**Member Focused Barriers:** • Immunizations may be done in community and not reported to PCP • Child comes in for "sick" visit and is not immunized, does not return for well visit • Parents unaware of immunization schedule • Parent believes risks outweigh benefits • Cultural or religious beliefs • Language barrier • Lack of parental knowledge • Immunizations given outside	**Member Focused Interventions:** • Encouragement of parents to bring in immunization records and put copy in medical record through collaboration with practitioner offices • Education of parents. Work with PCP to encourage parents to make informed decisions • Outreach: reminder postcards, birthday postcards, telephone reminders, and mailings • Publication of Preventive Health Guidelines on HMO websites and in

Nevada Average 52% **National Average 76%**	**Nevada Average 59%** **National Average 77%**	**Nevada Average 52.6%** **National Average 73.4%**	recommended schedule • Parental inability to locate immunization records • Lack of time, parents often must take off work • Parents do not want to pay co-payment for well child visit, if solely for immunizations • Impact of current economic conditions on member's ability to afford co-pay, limiting access to services • Media reports that create perceptions of adverse outcomes • Member/parent does not establish relationship with selected PCP **Practitioner Focused Barriers:** • Non-pediatric PCPs may not be aware of current immunization guidelines, Practitioner not proactive • Practitioner provides immunization, and then unable to or does not log data into State Registry • Practitioner refers parent to local/community public health authorities for immunizations • Variable Plan reimbursements to practitioners for vaccine/well visit • Practitioner not aware of his/her influence on parent compliance **Other Barriers:** • Transient population • The measure requires 1 year of continuous enrollment, but requires immunizations be done by the second birthday • State discontinued universal vaccine coverage, effective January 1, 2009 **Plan Barriers:** • Data completeness: difficult to capture data from non-Plan practitioners	Newsletters • Availability of information in English and Spanish • Implementation of Northern Nevada Immunization Coalition Project: Protect and Immunize Nevada's Kids (PINK), a hospital-based educational program for new mothers • Distribution of letters to parents of whose child is turning 2 or 13 in the upcoming year **Practitioner Focused Interventions:** • Education of practitioner on CDC guidelines for immunization when child has minor illness • Publication of Preventive Health Guidelines published on HMO websites • Articles in Practitioner Newsletters Surveys of PCP offices to determine awareness and utilization of web-based registry. If not utilizing, determine barriers. • Practitioner Newsletter articles and mailings on utilization of web-based state registry and mandatory participation reminder • Education of PCPs on importance of tracking immunizations • Education of practitioners to submit claims for vaccine, as well as the claim for administration of the vaccine • Mailing to all pediatricians that included: a) tablet of revised immunization forms, that promoted improved documentation b) information encouraging the use of the state registry c) exam room poster reminding parents to keep child's immunizations current **Other Interventions:** • Participation as members of the Nevada Immunization Coalitions • Effective July 1, 2009, mandatory reporting of vaccinations to the Nevada Immunization Registry

NEVADA HMOs COMPREHENSIVE DIABETES CARE – HbA1c Testing for COMMERCIAL POPULATIONS in 2009

Diabetes is one of the most costly and prevalent chronic diseases in the United States. It is estimated that over 6 million Americans are unaware that they have the disease. Complications

from diabetes cost the country over $132 billion annually, and diabetes-related conditions account for nearly 20 percent of all deaths in persons over 25. The hemoglobin A1c test (HbA1c) reveals average blood glucose over a period of two to three months. This has become the gold standard for assessing and monitoring glycemic control in patients with Type I and Type II diabetes. Appropriate and timely blood glucose management can significantly reduce the long-term complications from diabetes.

Measurement Criteria

Rate: The percentage of members, 18 – 75 years of age, with diabetes (Type I or Type II), continuously enrolled for the measurement year that had one or more HbA1c tests.

Numerator: One (or more) HbA1c test(s) performed during the measurement year

Denominator: The eligible population. *Optional exclusions*: 1). Members with a diagnosis of polycystic ovaries and no face-to-face encounters with a diagnosis of diabetes in any setting. 2). Members with a diagnosis of gestational or steroid-induced diabetes and no face-to-face encounters with a diagnosis of diabetes in any setting.

Chart 4. 2009 Comprehensive Diabetes Care - HbA1c Testing Rates for Commercial Populations

Table 4A: 2009 Comprehensive Diabetes Care - HbA1c Testing Rates for Commercial Populations

Nevada Licensed HMO	Patients Screened	Total Eligible Patients	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			89.15%			
Nevada HMO Average	2,485	2,975	83.55%	1.46	82.10%	85.01%
Aetna Health Inc.	318	406	78.33%	4.54	73.79%	82.86%
Health Plan of Nevada	471	575	81.91%	3.48	78.43%	85.39%
HMO Nevada	127	146	86.99%	5.87	81.11%	92.86%
Hometown Health	460	548	83.94%	3.36	80.58%	87.30%
PacifiCare	473	568	83.27%	3.37	79.91%	86.64%
Saint Mary's HealthFirst	636	732	86.89%	2.63	84.26%	89.51%

Summary

There has been a steady increase on this measure in Nevada for several years. The 2009 Nevada average was 83.55 percent, an almost 2.5 percent increase from the previous year. While it is over 5 percentage points below the 89 percent national average, there has been improvement over the past five years. Table 4B outlines the comprehensive efforts the HMOs are making for improving this rate.

An improvement in the HEDIS® rates for this measure was achieved through a variety of direct-to-member intervention strategies. The literature validates that repetitive and sequential activities can have a compounding effect on changing behavior and encouraging compliance with medical recommendations. The person's readiness to change their behavior might coincide with a reminder that just months before might have not been received or acted upon.

Table 4B. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Comprehensive Diabetes – HbA1c Testing in 2009

2007 Results	2008 Results	2009 Results	Barrier Analysis	Interventions To Address Barriers
Nevada Average 78% **National Average 88%**	**Nevada Average 81%** **National Average 89%**	**Nevada Average 83.6%** **National Average 89.2%**	**Member Focused Barriers:** • Member not aware of importance of HbA1c testing • Member fears results • Member has long wait at the lab • Member uses a non-Plan lab, making it difficult for Plan to retrieve results • Non-compliance with blood glucose management • Impact of current economic conditions on member's ability to	**Member Focused Interventions:** • Distribution of mailings to members informing them of the importance of HbA1c testing • Greater availability of educational materials in Spanish and for those with impaired reading/health literacy • Availability of Preventive Guidelines on HMO website, including self-management tools and lifestyle change resources • Print and Electronic Newsletter articles • Individual member incentives • List of Plan laboratories accessible on HMO website • Implementation of comprehensive disease management programs to help members with diabetes better self-monitor their disease management and enhance management efforts by their practitioners

			afford co-pay, limiting access to services • Member does not establish relationship with selected PCP **Practitioner Focused Barriers:** • Practitioner has ineffective tracking mechanism for identifying who needs testing or when test was last performed • Endocrinologists not communicating with PCPs • Varying physician practice patterns **Plan Barriers:** • Data completeness: difficult to capture data from non-Plan practitioners • Inability to obtain data from military agencies and the VA system	• Targeted interventions for higher risk members, to better to identify members at higher risk of complications, including increased healthcare utilization • Customized mailing to members with diabetes requiring current HbA1c test, notifying them of last date of service. Copy sent to PCP. • Members sent diabetes calendars, including test reminders, and educational materials regarding preventive measures and standards of care **Practitioner Focused Interventions:** • Distribution annually of Clinical Practice Guidelines (CPG) for Diabetes • Accessibility of CPGs on HMO website • Distribution to PCPs of compliance rates and list of members who have not received recommended diabetic screenings, to ensure appropriate follow-up • Implementation of comprehensive disease management programs to assist practitioners with management of their diabetic patients • Individual practitioner incentives **Plan Interventions:** • Surveys of non-compliant members to assess data completeness and potential barriers

NEVADA HMOs' EMERGENCY DEPARTMENT VISIT RATES for COMMERCIAL POPULATIONS in 2009

Emergency Department (ED) services often deliver non-emergency care and may sometimes be used as a substitute for ambulatory clinic encounters. While patient behavior is a factor in the decision to use an ED instead of a clinic or physician's office, the decision may be caused by insufficient access to primary care. Therefore, trends in ED utilization are an important aspect of total utilization data.

Measurement Criteria

Rate: The number of Emergency Department visits, per 1,000 member years. Each visit to an ED that does not result in an inpatient stay is counted only once, regardless of the intensity of care required during the stay or length of stay.

As specified in HEDIS® methodology, only one ED visit per date of service is counted. Urgent care visits and certain mental health and chemical dependency services are excluded.

Numerator: (Total Number of ED Visits / Member Months) x 1,000 x 12

Denominator: The eligible population

Chart 5. 2009 Emergency Department Visits per 1,000 Members per Year for Commercial Populations

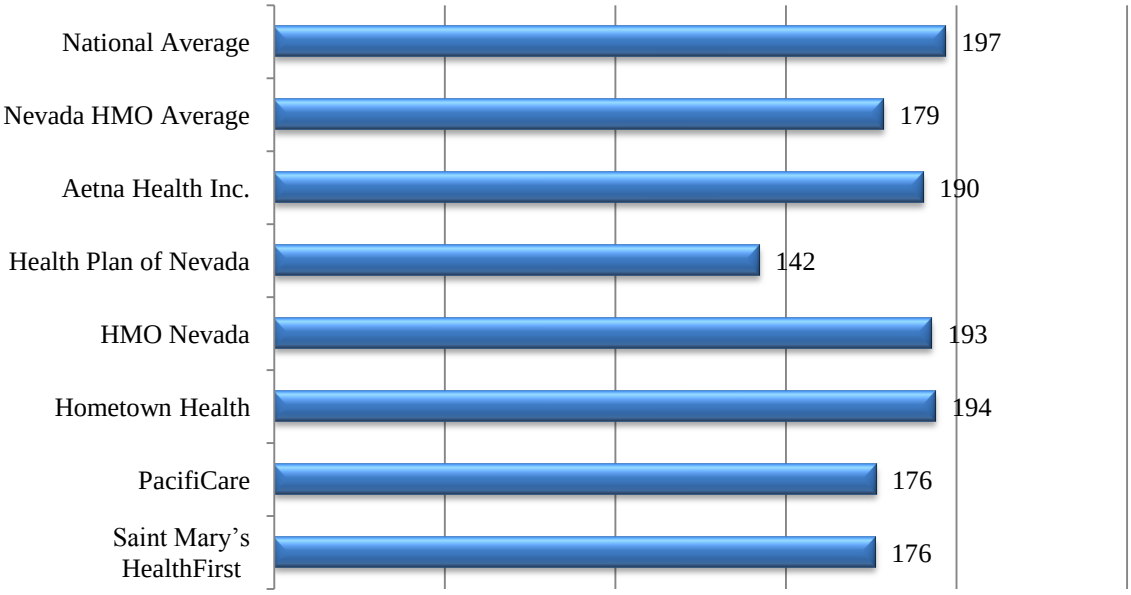


Table 5A: 2009 Emergency Department Visits per 1,000 Members per Year for Commercial Populations

Nevada Licensed HMO	Emergency Room Visits	Total Member Months	Visits/1,000 Members per year
National Average			196.69
Nevada HMO Average	55,102	1,163,943	178.61
Aetna Health Inc.	2,052	129,402	190.29
Health Plan of Nevada	41,630	292,731	142.21
HMO Nevada	1,036	64,522	192.68
Hometown Health	4,794	296,773	193.85
PacifiCare	1,945	132,299	176.42
Saint Mary's HealthFirst	3,645	248,216	176.22

Summary

The 2009 Nevada average for Emergency Department Visits is 178.61 visits per 1,000 members per year, almost 18 visits less than the national average of 196.69 visits per 1,000 members per year. While the Nevada average has increased, it continues to outperform the National average each year. Considering the current economic climate, this trend may not continue in future years, particularly if it impacts the member's ability to access non-emergent services. Table 5B outlines the comprehensive efforts the HMOs are making to improve both the Nevada average and the appropriate use of the ED.

Table 5B. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Emergency Department Visit Rates in 2009

2007 Results	2008 Results	2009 Results	Barrier Analysis	Interventions To Address Barriers
Nevada Average 171 **National Average 201**	**Nevada Average 174** **National Average 195**	**Nevada Average 178.6** **National Average 196.7**	**Member Focused Barriers:** • Member does not establish relationship with selected PCP and/or may not be aware of PCP's office hours • Member not able to distinguish urgent and emergent care needs • Member wants choice and convenience • Member not aware of urgent care benefit and locations and/or hours • Member finds that 24-hour urgent care availability is limited • Impact of current economic conditions on member's ability to afford co-pay, limiting access to non-emergent services **Practitioner Focused Barriers:** • Member is inappropriately directed to ED by PCPs and/or Specialist, as per after hours phone messages • Inappropriate referral to place and level of service (i.e., urgent care vs. emergent care) **Plan Barriers**: • Northern Nevada has proportionately fewer urgent care facilities, and the resulting fewer hours of operation and days of service lower urgent care accessibility in this part of the state	**Member Focused Interventions:** • Education of members on Urgent Care Benefit and encourage appropriate utilization • Nurse triage line for appropriate utilization of services • Member education of urgent versus emergent care needs • Member education materials about urgent care services, locations, and hours **Practitioner Focused Interventions:** • After hours availability surveys of practitioner offices • Expand urgent care network to address more comprehensive range of services • Education regarding appropriate referrals to ED versus Urgent Care **Plan Interventions:** • Extension of available hours and days of services offered by Urgent Care facilities • Assess range of services currently being provided for adequacy in meeting community and member needs

NEVADA HMOs ADULTS' ACCESS RATES to PREVENTIVE/AMBULATORY HEALTH SERVICES for COMMERCIAL POPULATIONS in 2009

This measurement examines the percentage of members who have had an ambulatory or preventive care visit to their physician. Members who do not access preventive health care have a higher likelihood of developing preventable or advanced diseases with increased personal and financial costs. Health Plans utilize this measure for the analysis and systematic removal of barriers to care.

Measurement Criteria

Rates: The percentage of members 20 years and older, in three age stratification bands, continuously enrolled for the measurement year and the two years prior to the measurement year,

who had an ambulatory or preventive care visit. To remain consistent with HEDIS® guidelines, each age group is represented separately. A graph with the Nevada HMO average of all ages follows.

Numerators: Members age 20-44, 45-64, and 65 and older, who had one (or more) ambulatory or preventive care visit(s) during the measurement year or the two years prior to the measurement year.

Denominators: The eligible populations

Chart 6A. 2009 Adults' Access Rates to Preventive/Ambulatory Health Services for Commercial Populations (Age 20-44 years)

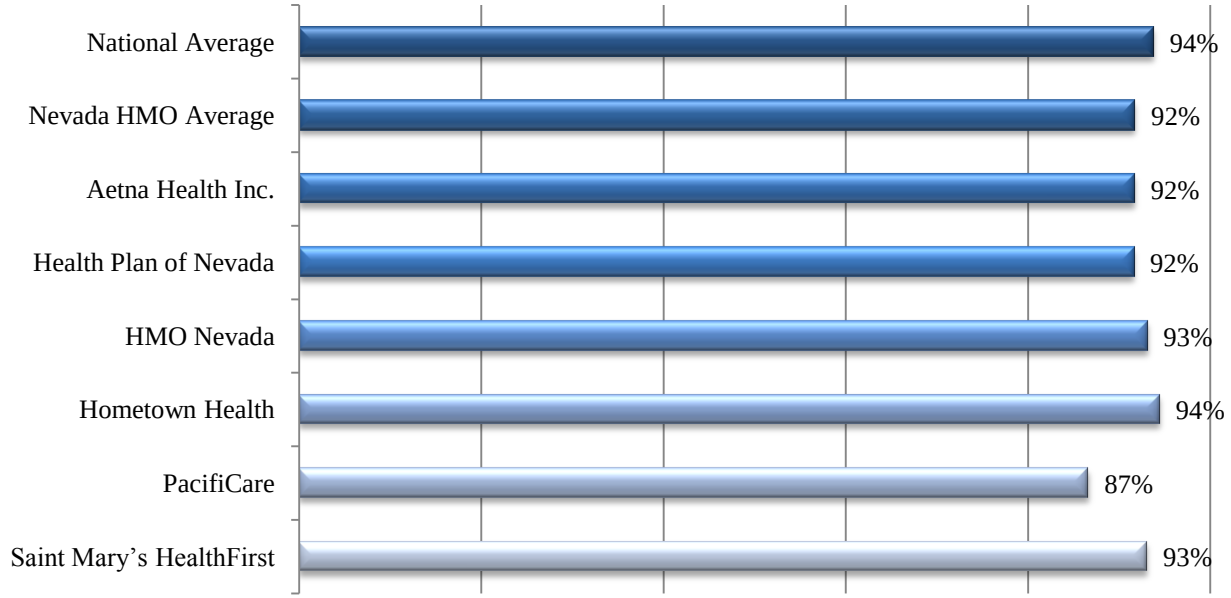


Table 6A: 2009 Adults' Access Rates to Preventive/Ambulatory Health Services (Age 20-44 years) for Commercial Populations

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			93.77%			
Nevada HMO Average	47,992	52,338	91.75%	0.25	91.50%	91.99%
Aetna Health Inc.	861	939	91.69%	1.84	89.85%	93.54%
Health Plan of Nevada	39,489	43,106	91.61%	0.27	91.34%	91.88%
HMO Nevada	175	188	93.09%	3.77	89.32%	96.85%
Hometown Health	2,871	3,040	94.44%	0.84	93.60%	95.28%
PacifiCare	1,570	1,813	86.60%	1.69	84.91%	88.28%
Saint Mary's HealthFirst	3,026	3,252	93.05%	0.91	92.14%	93.96%

Summary

The 2009 Nevada average of 91.75 percent is similar to the previous year for the age group 20-44 years and remains 3 percentage points above the 2007 average and only 2 percentage points below the national average of 93.77 percent. Table 6F outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

Chart 6B. 2009 Adults' Access Rates to Preventive/Ambulatory Health Services for Commercial Populations (Age 45-64 years)

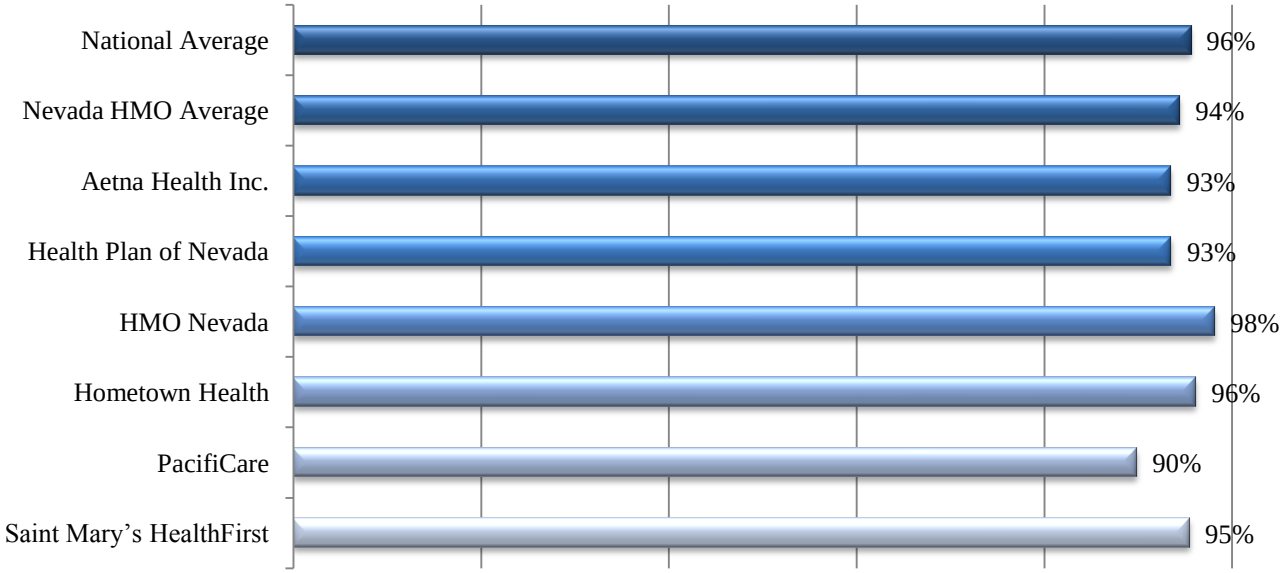


Table 6B: 2009 Adults' Access Rates to Preventive/Ambulatory Health Services (Age 45-64 years) Commercial Populations

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			95.57%			
Nevada HMO Average	56,987	60,856	94.40%	0.19	94.21%	94.58%
Aetna Health Inc.	1,027	1,099	93.45%	1.51	91.93%	94.96%
Health Plan of Nevada	46,469	49,704	93.49%	0.22	93.27%	93.72%
HMO Nevada	209	213	98.12%	1.84	96.28%	99.97%
Hometown Health	3,023	3,146	96.09%	0.69	95.40%	96.78%
PacifiCare	2,051	2,284	89.80%	1.31	88.49%	91.11%
Saint Mary's HealthFirst	4,208	4,410	95.42%	0.63	94.79%	96.05%

Summary

The 2009 Nevada Average of 94.4 percent is similar to the previous year for the group age 45-64. This is just below a percent the national average of 95.6 percent. Table 6F outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

Chart 6C. 2009 Adults' Access Rates to Preventive/Ambulatory Health Services for Commercial Populations* (Age 65+ years)

Table 6C: 2009 Adults' Access Rates to Preventive/Ambulatory Health Services (Age 65+) for Commercial Populations

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			96.83%			
Nevada HMO Average	6,955	7,261	95.66%	0.48	95.18%	96.14%
Aetna Health Inc.	152	165	92.12%	4.30	87.82%	96.42%
Health Plan of Nevada	5,477	5,726	95.65%	0.54	95.11%	96.19%
HMO Nevada	20	21	95.24%	9.58	85.66%	104.81%
Hometown Health	319	329	96.96%	1.89	95.07%	98.85%
PacifiCare	541	569	95.08%	1.82	93.25%	96.90%
Saint Mary's HealthFirst	446	451	98.89%	0.97	97.92%	99.86%

Summary

The 2009 Nevada average of 95.66 percent is approximately the same as 2008 at 96 percent for the age group 65 and older, is 2 percentage points higher than the 2007 average, and 1

percentage point below the National average of 96.83 percent. Table 6F outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

The following graph provides the overall HMO average rates and Nevada average for all adult age groups (age 20 years and older).

Chart 6D. 2009 Adults' Access Rates to Preventive/Ambulatory Health Services for Commercial Populations (Nevada Average for Age 20 years and older)

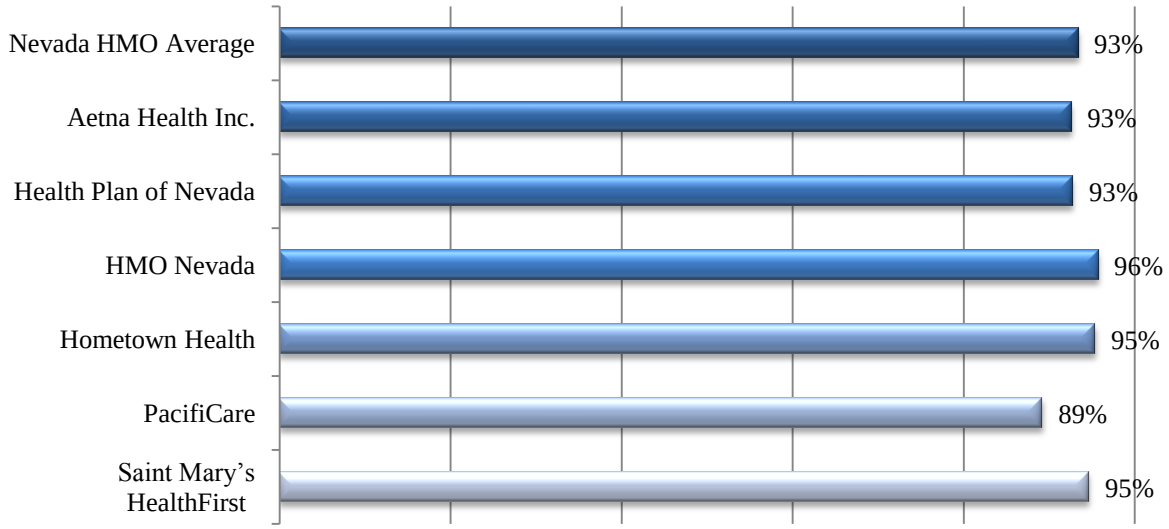


Table 6D: 2009 Adults' Access Rates to Preventive/Ambulatory Health Services for Commercial Populations (Nevada Average for Age 20 years and older)

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
Nevada HMO Average	111,934	120,455	93.39%	0.15	93.25%	93.54%
Aetna Health Inc.	2,040	2,203	92.60%	1.14	91.46%	93.74%
Health Plan of Nevada	91,435	98,536	92.79%	0.17	92.63%	92.96%
HMO Nevada	404	422	95.73%	1.97	93.76%	97.71%
Hometown Health	6,213	6,515	95.36%	0.52	94.84%	95.89%
PacifiCare	4,162	4,666	89.20%	0.94	88.26%	90.14%
Saint Mary's HealthFirst	7,680	8,113	94.66%	0.50	94.16%	95.17%

Summary

The HEDIS® National average for the total adult access is 94.90 percent. The 2009 Nevada average of 93.39 percent is slightly less than 1 percent lower than the National average. Table 6E details adult access rates by age stratification for the last 4 years, and Table 6F outlines the comprehensive efforts the Nevada HMOs are making to improve these rates.

Table 6E: Adults' Access Rates to Preventive/Ambulatory Health Services, by Age Stratification, 2007 – 2009

	2007 Averages		2008 Averages		2009 Averages	
Age Group	**Nevada**	**National**	**Nevada**	**National**	**Nevada**	**National**
20 – 44 years	88%	93%	91%	93%	92%	94%
45 – 64 years	92%	95%	93%	95%	94%	96%
65+ years	96%	97%	96%	97%	96%	97%
All ages	90%	N/A	92%	N/A	93%	95%

Table 6F. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Adults' Access Rates to Preventive/Ambulatory Health Services (all age groups) in 2009

2007 Results	2008 Results	2009 Results	Barrier Analysis	Interventions To Address Barriers
Nevada Average 90%	**Nevada Average 92%**	**Nevada Average 93.4%**	**Member Focused Barriers:** • Member does not establish relationship with selected PCP prior to needing care • Member does not find first available appointment acceptable • Member has no time • Member's co-pay cost is too high • Member only accesses care when ill • Member is deterred from accessing and/or receiving services due to cultural issues • Impact of current economic conditions on member's ability to afford co-pay, limiting access to services **Practitioner Focused Barriers:** ▪ Practitioner not aware of his/her influence on member ▪ Practitioner does not encourage follow up **Plan Focused Barriers:** • Potential underreporting of services due to incomplete capture of encounter data from capitated practitioners • Data completeness: difficult to capture data from non-Plan practitioners • Inability to obtain data from military agencies and the VA system	**Member Focused Interventions:** • Publication of Preventive Guidelines on the HMO website • Articles on preventive care in member newsletters **Practitioner Focused Interventions:** • Secret shopper surveys of practitioner offices • Office site visits with check for appointment availability • Requirements for practitioners to submit encounter data for capitated contract arrangements • Practitioner education of Plan's access and availability standards • Publication and distribution of Preventive Guidelines to all practitioners annually and/or on HMO websites **Plan Interventions**: • Monitoring of practitioners' compliance to Plan access/availability standards

NEVADA HMOs CHILDREN and ADOLESCENTS ACCESS RATES to PRIMARY CARE PRACTITIONERS for COMMERCIAL POPULATIONS in 2009

This measure emphasizes the importance of routine care and developmental exams for children, and looks at health plan providers of primary care as a way to assess general access to care for children and adolescents. Children who do not access preventive health care have a higher likelihood of developing advanced and preventable diseases, are most likely to benefit from early diagnosis, and may experience delayed diagnosis of hearing, speech and vision difficulties.

Measurement Criteria

Rates: The percentage of members 12 months – 19 years of age, continuously enrolled for the measurement year and the year prior to the measurement year, as applicable, who had a visit with a Primary Care Practitioner (PCP).

Numerators:

For 12-24 months and 25 months-6 years: One (or more) visit(s) with a PCP during the measurement year

For 7-11 years and 12-19 years: One (or more) visit(s) with a PCP during the measurement year or the year prior to the measurement year

Denominators: The eligible populations

Chart 7A. 2009 Children and Adolescents' Access Rates To Primary Care Practitioners for Commercial Populations (Ages 12-24 months)

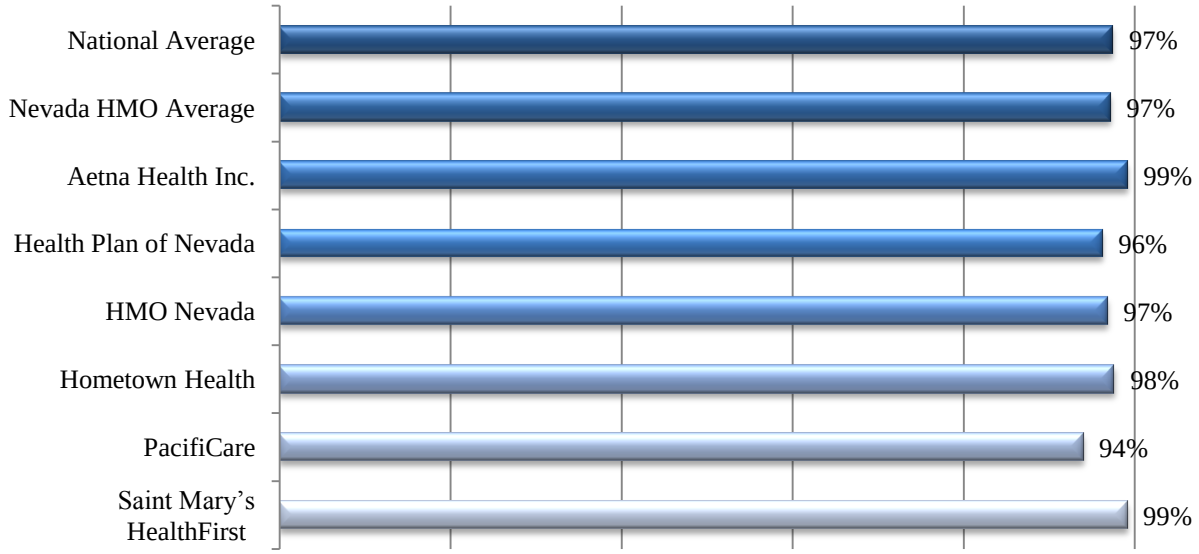


Table 7A: 2009 Children and Adolescent's Access Rates to Primary Care Practitioners Rates for Commercial Populations (Ages 12-24 months)

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			97.46%			
Nevada HMO Average	3,994	4,139	97.14%	0.52	96.63%	97.66%
Aetna Health Inc.	114	115	99.13%	1.71	97.42%	100.84%
Health Plan of Nevada	3,201	3,327	96.21%	0.66	95.55%	96.87%
HMO Nevada	61	63	96.83%	4.44	92.39%	101.26%
Hometown Health	286	293	97.61%	1.77	95.84%	99.38%
PacifiCare	109	116	93.97%	4.49	89.47%	98.46%
Saint Mary's HealthFirst	223	225	99.11%	1.23	97.88%	100.35%

Summary

The 2009 Nevada average of 97.14 percent is slightly higher than the 2008 average of 95 percent and almost equal to the National average of 97.46 percent. Table 7G outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

Chart 7B. 2009 Children and Adolescents' Access Rates To Primary Care Practitioners for Commercial Populations (Ages 25 months - 6 years)

Table 7B: 2009 Children and Adolescent's Access Rates to Primary Care Practitioners Rates for Commercial Populations (Ages 25 months - 6 years)

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			91.59%			
Nevada HMO Average	17,572	20,700	86.37%	0.51	85.86%	86.88%
Aetna Health Inc.	459	537	85.47%	3.23	82.25%	88.70%
Health Plan of Nevada	14,016	16,655	84.15%	0.60	83.55%	84.76%
HMO Nevada	264	301	87.71%	3.97	83.74%	91.68%
Hometown Health	1,417	1,572	90.14%	1.55	88.59%	91.69%
PacifiCare	477	589	80.98%	3.53	77.46%	84.51%
Saint Mary's HealthFirst	939	1,046	89.77%	1.94	87.83%	91.71%

Summary

The 2009 Nevada average of 86.37 percent is 3 percentage points higher than the previous year and is over 5 percentage points below the National average of 91.59 percent. Table 7G outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

Chart 7C. 2009 Children and Adolescents' Access Rates To Primary Care Practitioners for Commercial Populations (Ages 7-11 years)

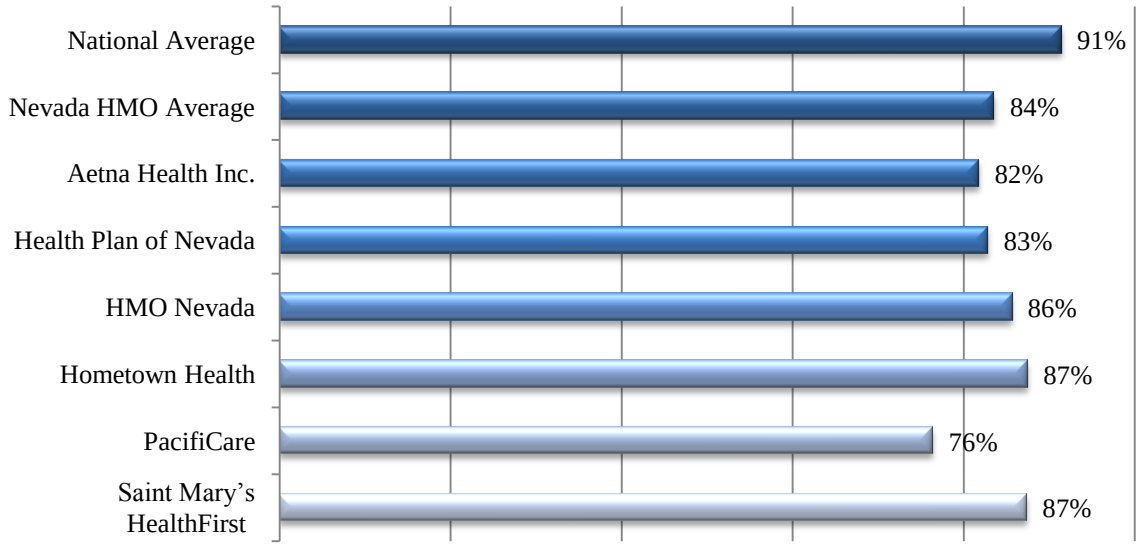


Table 7C: 2009 Children and Adolescent's Access Rates to Primary Care Practitioners Rates for Commercial Populations (Ages 7-11 years)

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			91.41%			
Nevada HMO Average	14,204	17,091	83.56%	0.61	82.95%	84.17%
Aetna Health Inc.	224	274	81.75%	5.07	76.68%	86.82%
Health Plan of Nevada	11,689	14,117	82.80%	0.68	82.12%	83.49%
HMO Nevada	268	313	85.62%	4.21	81.41%	89.83%
Hometown Health	816	933	87.46%	2.27	85.19%	89.73%
PacifiCare	440	576	76.39%	3.97	72.42%	80.36%
Saint Mary's HealthFirst	767	878	87.36%	2.35	85.00%	89.71%

Summary

The 2009 Nevada average of 83.56 percent is over 3 percentage points higher than the previous year's of 80 percent. It was lower than the National average of 91.41 percent by almost 8 percentage points. Table 7G outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

Chart 7D. 2009 Children and Adolescents' Access Rates To Primary Care Practitioners for Commercial Populations (Ages 12-19 years)

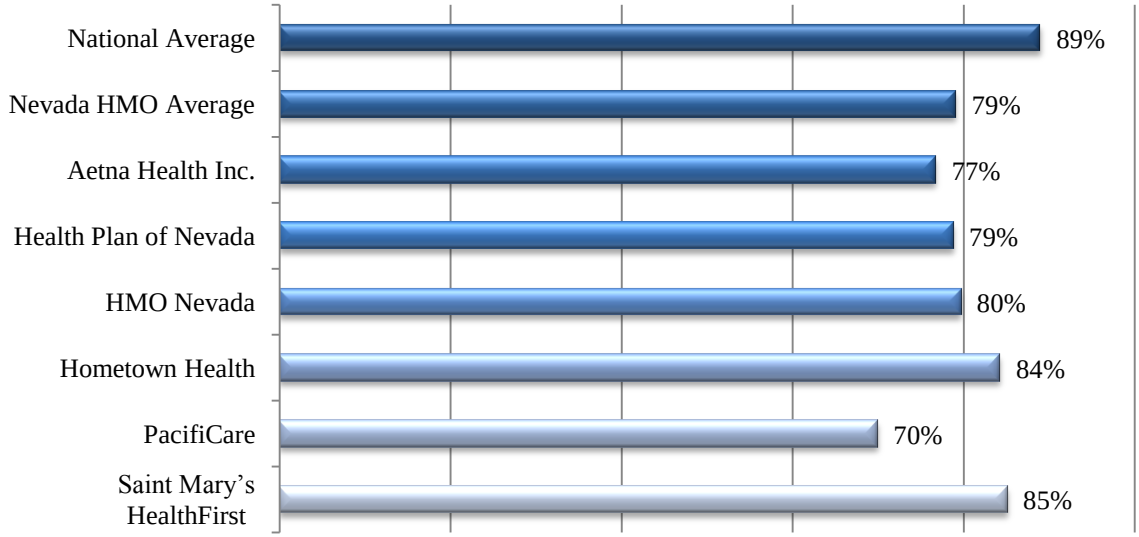


Table 7D: 2009 Children and Adolescent's Access Rates to Primary Care Practitioners Rates for Commercial Populations (Ages 12-19 years)

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
National Average			88.96%			
Nevada HMO Average	22,740	28,757	79.07%	0.53	78.55%	79.60%
Aetna Health Inc.	402	524	76.72%	4.14	72.58%	80.85%
Health Plan of Nevada	18,755	23,809	78.77%	0.59	78.19%	79.36%
HMO Nevada	298	374	79.68%	4.58	75.10%	84.26%
Hometown Health	1,263	1,499	84.26%	2.01	82.25%	86.27%
PacifiCare	686	981	69.93%	3.43	66.49%	73.36%
Saint Mary's HealthFirst	1,336	1,570	85.10%	1.91	83.19%	87.01%

Summary

The 2009 Nevada average of 79.07 percent represents an increase from the previous year of over 4 percent, but remains 10 percentage points below the National average of 88.96 percent. Table 7G outlines the comprehensive efforts the Nevada HMOs are making to improve this rate.

The following graph provides the overall HMO average rates and Nevada average for all age stratifications (age 12 months to 19 years).

Chart 7E. 2009 Children and Adolescents' Access Rates To Primary Care Practitioners for Commercial Populations (Nevada Average for Ages 12 months to 19 years)

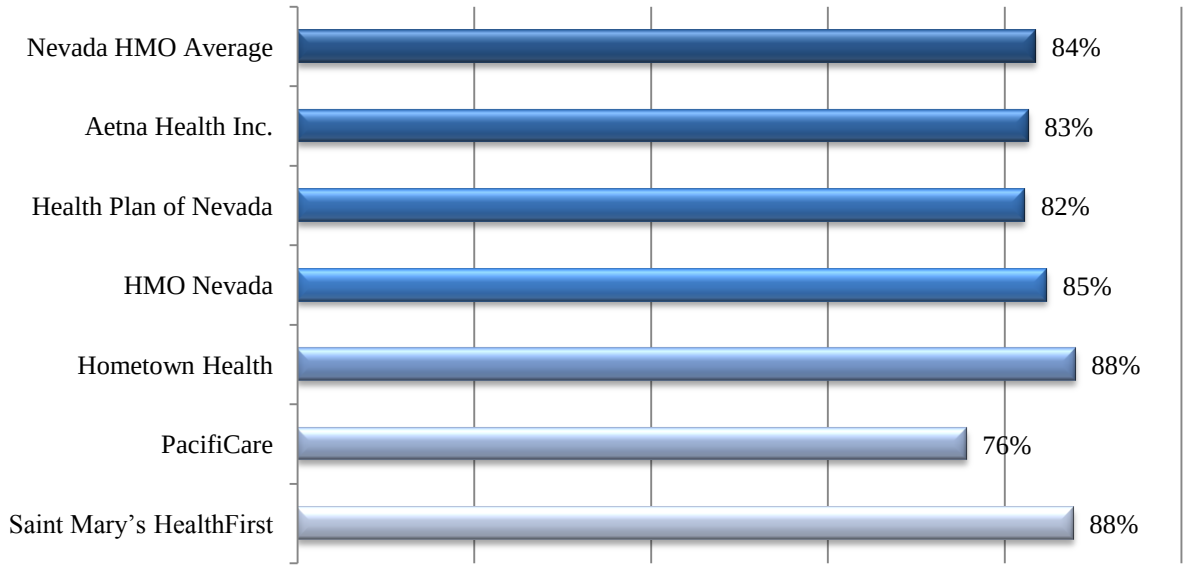


Table 7E: 2009 Children and Adolescent's Access Rates to Primary Care Practitioners for Commercial Populations (Nevada Average for Ages 12 months to 19 years)

Nevada Licensed HMO	Numerator	Denominator	Rate	±95% CI	Lower Bound 95% CI	Upper Bound 95% CI
Nevada HMO Average	58,510	70,687	83.54%	0.30	83.24%	83.84%
Aetna Health Inc.	1,199	1,450	82.69%	2.14	80.55%	84.83%
Health Plan of Nevada	47,661	57,908	82.30%	0.34	81.96%	82.65%
HMO Nevada	891	1,051	84.78%	2.36	82.42%	87.14%
Hometown Health	3,782	4,297	88.01%	1.04	86.98%	89.05%
PacifiCare	1,712	2,262	75.69%	2.03	73.65%	77.72%
Saint Mary's HealthFirst	3,265	3,719	87.79%	1.12	86.67%	88.92%

Summary

HEDIS® does not calculate a comprehensive national average for this measure. The 2009 Nevada average of 83.54 percent is higher than the two previous years, each at 80 percent (rounded). Table 7F details children and adolescent access rates by age stratification, for the last 4 years, and Table 7G outlines the comprehensive efforts the Nevada HMOs are making to improve these rates.

Table 7F: Children and Adolescents' Access Rates to Primary Care Practitioners, by Age Stratification, in 2007 – 2009

	2007 Averages		2008 Averages		2009 Averages	
Age Group	**Nevada**	**National**	**Nevada**	**National**	**Nevada**	**National**
12 – 24 months	96%	97%	95%	97%	97%	98%
25 months–6 yrs	83%	89%	83%	90%	86%	92%
7 – 11 years	79%	90%	80%	90%	84%	91%
12 – 19 years	74%	87%	75%	87%	79%	89%
All ages	80%	N/A	80%	N/A	83%	N/A

Table 7G. Nevada HMOs Quality Indicator Barrier Analysis and Interventions for Children and Adolescents' Access Rates to Primary Care Practitioners (all age groups) in 2009

2007 Results	2008 Results	2009 Results	Barrier Analysis	Interventions To Address Barriers
Nevada Average 80%	**Nevada Average 80%**	**Nevada Average 83.5%**	**Member Focused Barriers:** • Member has dual coverage; children may be accessing services under another insurer • Member/parent does not establish relationship with selected PCP prior to needing care • Member receives child well visit services (e.g. immunizations) in the community and not reported to the Health Plan • Member/parent has time constraint • Member accesses care only when ill • Impact of current economic conditions on member's ability to afford co-pay, limiting access to services and/or delaying time to seek treatment • Traditional office hours may be obstacle for parents who are unable to take time off of work **Practitioner Focused Barriers:** • Practitioner not aware on his/her influence on member compliance • Practitioner does not encourage follow up **Plan Focused Barriers:** • Potential under reporting of services due to incomplete capture of encounter data from capitated practitioners • Data completeness: difficult to capture data from non-Plan practitioners • Inability to obtain data from military agencies and the VA system	**Member Focused Interventions:** • Publication of Preventive Guidelines on the HMO website • Articles on preventive care in member newsletters • Telephonic reminder for well child and adolescent check-ups and immunizations • Birthday cards to children and adolescents encouraging preventive care • Offering of incentive to members for well child/adolescent check-ups • Proactive written notification to parents regarding importance of preventative services **Practitioner Focused Interventions:** • Secret shopper surveys of practitioner offices • Office site visits with check for appointment availability • Requirement for the practitioners to submit encounter data for capitated contract arrangements • Practitioner education of Plan's access and availability standards • Increases in the number of pediatricians in Plan network • Distribution of Preventive Guidelines to all practitioners annually and on HMO website

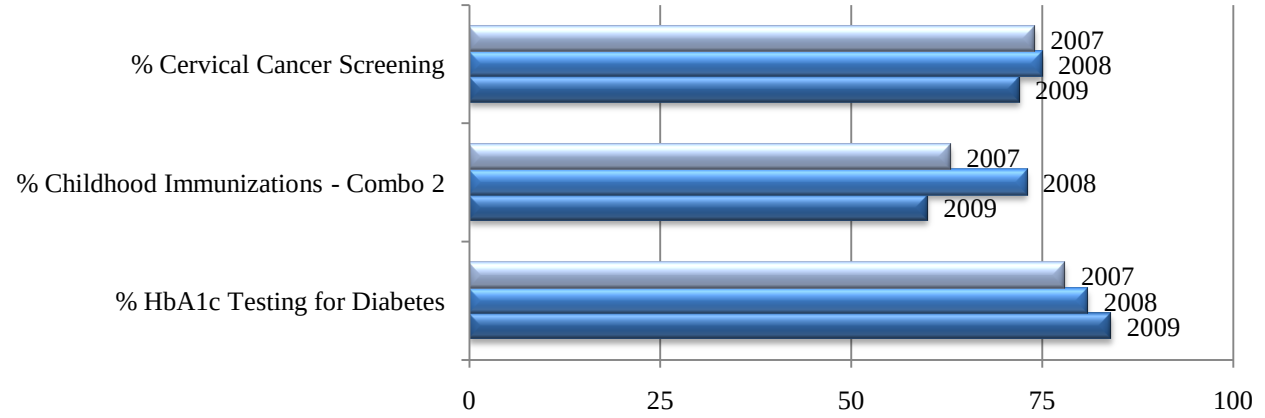
SECTION VI

NEVADA HMOs: 3-YEAR TRENDS, 2007 - 2009

Effectiveness of Care Measures

The HEDIS® Effectiveness of Care domain contains measures that examine the clinical quality of care delivered within a health plan from a variety of perspectives. Chart 8 provides available 3-year trend information for the required measures reported to the Nevada State Board of Health, by the Nevada HMOs providing care to commercial populations, which are part of the domain.

Chart 8. 3-Year Trends: Effectiveness of Care Measures



	% HbA1c Testing for Diabetes	% Childhood Immunizations - Combo 2	% Cervical Cancer Screening
2007	78	63	74
2008	81	73	75
2009	84	60	72

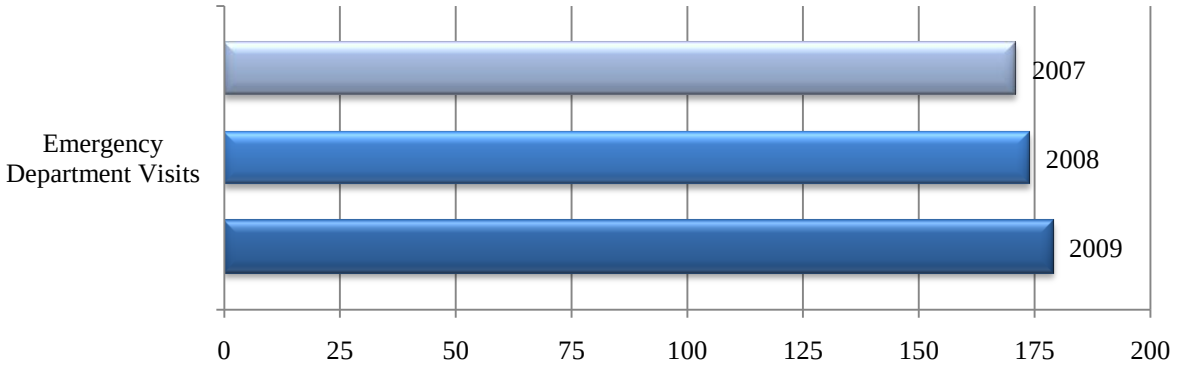
Summary

- **Cervical Cancer Screening**: Though the Nevada average has declined slightly in 2009, it still ranges within a few percentage points during this period (72-75 percent)
- **Childhood Immunization Status:** This measure declined in 2009, but the Nevada HMOs anticipate that the intervention strategies detailed earlier in this report will help them eventually reach the national benchmark.
- **Comprehensive Diabetes Care – HbA1c testing**: Since reporting began in 2005, this measure has shown overall improvement.

Use of Services Measure

The HEDIS® Use of Services domain contains measures which examine what services a health plan provides to its members and how the provision of care is managed. There are two types of measures in this domain: 1) those that express rates of service, often expressed as *per 1,000 member years (or months)* and 2) those that express the percentage of members who received certain services, in a manner similar to the Effectiveness of Care domain. One of the domain subsets is ambulatory care, which includes emergency department (ED) visits. EDs often deliver non-emergency care, and a health plan that promotes effective ambulatory treatment of members is usually able to reduce and maintain a lower number of ED visits. Chart 9 provides available 3-year trend information on ED visits for the Nevada HMOs' commercial populations, the only indicator from this domain required to be reported to the State Board of Health.

Chart 9. Emergency Department Visits/ Per 1,000 Members/Per Year



	Emergency Department Visits
2007	171
2008	174
2009	179

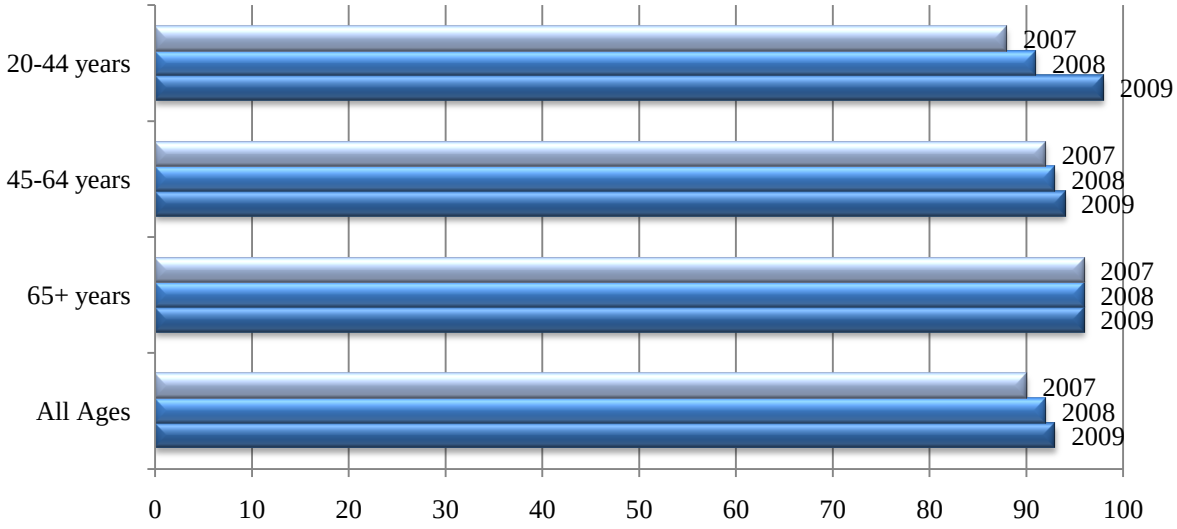
Summary

While Emergency Department Visits have increased from 171 to 179 visits per 1,000 members per year, the Nevada HMOs have been able to keep visits well below the national average, which has ranged from 188 – 201 visits per 1,000 members per year during the trend period.

Access/Availability of Care Measures

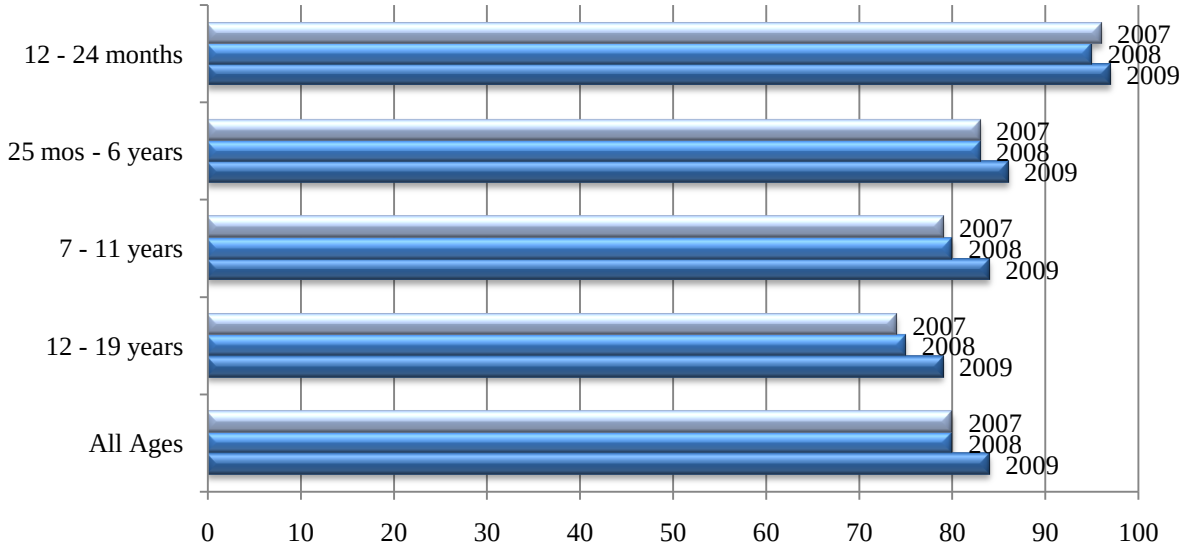
The HEDIS® Access/Availability of Care domain contains measures that examine how members access basic and important services offered by their health plan, including the ability to get the services they require from a health care system. The State Board of Health requires that two measures from this domain be reported by the HMOs serving commercial populations.

Chart 10A. 3-Year Trends: Access/Availability of Care Measures - Adults' Access to Preventive/Ambulatory Health Services



	All Ages	65+ years	45-64 years	20-44 years
2007	90	96	92	88
2008	92	96	93	91
2009	93	96	94	98

Chart 10B. 3-Year Trends: Access/Availability of Care Measures - Children and Adolescents' Access to Primary Care Practitioners



	All Ages	12 - 19 years	7 - 11 years	25 mos - 6 years	12 - 24 months
2007	80	74	79	83	96
2008	80	75	80	83	95
2009	84	79	84	86	97

Summary

- **Adults' Access to Preventive/Ambulatory Health Services**: The rates have generally improved over the past 3 years. While not significantly below the national averages, the Nevada HMOs anticipate that the intervention strategies detailed earlier in this report will help them eventually reach the national benchmarks.
- **Children and Adolescents' Access to Primary Care Practitioners**: The rates have generally improved.